Quality Improvement

Wisconsin Medicaid is committed to assuring quality, access, and choice to its Medicaid population and to being a proactive partner with the private sector in achieving the highest possible health outcomes for recipients. This is accomplished through various monitoring and oversight activities and public forums, known as Quality Improvement (QI) activities, as noted below.

HMO Program QI Activities

QI activities that relate to the AFDC/Healthy Start HMO program include:

- Contractual safeguards, such as the requirement that certified HMOs:
  - ✓ Meet fiscal and staffing standards of the Wisconsin Office of the Insurance Commissioner.
  - ✓ Ensure public transportation access to the clinic site, that the building is accessible to all enrollees, that there is adequate waiting space, and that enrollees have timely access to primary and specialty care providers.
  - ✓ Cover all mandated services, whether through internal staff or by contracted arrangements.
  - ✓ Provide emergency health care services 24 hours a day, seven days a week, and provide a single telephone number through which enrollees are able to access all services.
  - ✓ Provide an HMO advocate to assist recipients with using managed care effectively. Also, enrollment must be utilized to assist enrollees with the enrollment process, and ombudsmen to assist in the management of controversy regarding the delivery of managed health care services.
  - ✓ Have an established and available grievance procedure.
  - ✓ Provide preventive health care services in selected areas of health care.
  - ✓ Establish a working arrangement with community agencies to facilitate prenatal care coordination, with a goal of decreasing adverse outcomes of pregnancy.
  - ✓ Address the health care needs of the Medicaid population in a culturally sensitive fashion.
- The use of an independent enrollment counselor to ensure that Medicaid recipients enrolling in HMOs have a fully informed choice of providers.
- Establishing and maintaining ongoing methods for public, recipient, and provider input. Examples of this activity include a Statewide Advisory Group, quarterly meetings with HMO technical staff, quarterly regional forums, and work groups established to address specific areas of concern.
- Medicaid ombudsmen and advocates which are external to the HMOs.
- Measurement of recipient satisfaction.
- Production of this annual report on HMO-delivered care.
- Monitoring HMO disenrollment and grievance procedures.

Fee-for-Service QI Activities

- Reviews and audits of the health care services delivered to Medicaid enrollees in the outpatient and inpatient setting for appropriateness, medical necessity, and quality of care.
- Prospective review of selected services through prior authorization to assure recipients receive medically necessary and cost-effective services.
- Ongoing review of the utilization of drugs in outpatient and nursing home settings, to assure that prescriptions are appropriate, medically necessary, and not likely to result in adverse medical outcomes.

- Periodic audits and reviews of the medical services provided to Medicaid recipients with special needs, who may voluntarily enroll in special managed care programs.

Medical Chart Review and Audit Activities

On an ongoing basis, the Department of Health and Family Services engages in a variety of audits and medical chart reviews to assess the quality of care provided to Wisconsin Medicaid recipients. Some of these audits/chart reviews are on a case-specific or limited-scope basis, while others encompass a broad spectrum of care. The former usually represents a response to a specific complaint or grievance, while the latter generally reflects pre-planned assessments of areas of interest or concern to DHFS. Since the Medicaid population consists primarily of mothers and children, audits and chart reviews are principally designed to monitor the care of that population. (Issues important to Medicaid mothers and children center around prenatal care, women's health, child health and prevention, dental and mental health/substance abuse care.)

The greater proportion of medical audit/chart reviews, from a volume standpoint, is performed, under contract to DHFS, by an external review organization (ERO). Annually, about 20,000 fee-for-service inpatient and 800 ambulatory reviews are performed. The questionable quality of care cases identified by the contractor's physician advisors are referred to the BHCF physician staff for further disposition. The ERO annually also reviews approximately 2 percent of Medicaid HMO enrollees' care. Only a minute number of HMO cases renewed by the ERO have been found to represent "medical mismanagement with potential for significant adverse effects on the patient." No cases of "medical mismanagement with significant adverse effects on the patient" have been uncovered in recent years; this is a direct result of the identification of error-prone HMO providers in earlier audits and the HMOs' focused corrective action plans associated with provider education.

In addition to the ERO reviews, medical audit/chart reviews are personally performed by DHFS staff, with and without outside experts, on an ongoing basis. Two areas of recent review have been mental health/substance abuse and dental care, with a focus on both quality of care and access to care. A pervasive problem identified in both areas of review has been incomplete and/or inadequate documentation of services provided. While adequate documentation does not necessarily ensure good quality of care, it contributes to good care. Recent follow-up audits have verified substantial improvements in documentation subsequent to DHFS' previous identification of this problem, followed by education of responsible HMO providers. Lack of a thorough initial patient assessment by psychiatrists, as well as non-psychiatrist mental health/substance abuse providers, has also been found to be a problem. The latter provider group has demonstrated continual improvement over time, while the former needs further education by HMOs and reassessments by DHFS.

Data validity audits, performed by DHFS or contracted staff, have been utilized recently to assist DHFS in verifying the accuracy and completeness of utilization data submitted to DHFS by HMOs. The preliminary findings of a recent multiple-HMO data validity audit underscores the inherent difficulty DHFS has in obtaining uniform utilization and quality of care data from HMOs. The results of the data validity audit will be presented to respective HMOs in the near future and will be an ongoing HMO surveillance effort by the BHCF.

Access to Care

Access to care is difficult to determine. In part it depends on patient perceptions of availability and timeliness of medical care. Access is measured in this report by the interrelationship of selected health care utilization parameters. Those parameters include: the rate of acute and preventive care visits, primary provider visits, and emergency room visits. The 1996 utilization data show, respectively, a slightly reduced rate of acute/preventive care visits, a much greater rate of primary provider visits, and a significantly reduced rate of emergency room visits by HMO enrollees when contrasted with fee-for-service recipients. The utilization rates, viewed together with an extremely rare occurrence of enrollee access complaints, strongly suggest that Wisconsin Medicaid-contracted HMOs are providing a "medical home" for Medicaid enrollees, thereby enhancing their access to care.

SELECTED FINDINGS:

- All HMOs reported substantially more enrollee visits to primary care providers than fee-for-service. (The HMO average number of visits was 2.51, in fee-for-service it was 0.73.)
- All but one HMO (eight of nine) reported much lower emergency room utilization rates than fee-for-service. (The HMO average was .51 visits per eligible-year, while it was .69 in fee-for-service.)
- All but one HMO reported that emergency room visits made up a much smaller percentage of all ambulatory care visits than fee-for-service (8.4 percent of all HMO ambulatory visits were emergency room visits, while 15.6 percent of all fee-for-service ambulatory visits were to the emergency room).

What is "Access to Care" and Why Is It Important?

Access to care may be said to be the ability to obtain care when needed or desired, in a reasonably convenient manner. Access to care is a cornerstone of quality. Access in and of itself does not guarantee quality, but the availability of both preventive care and acute care treatment is fundamental to good health care.

Lack of "access to care" may contribute to adverse outcomes including avoidable hospitalizations, longer lengths of stay, poor birth outcomes, and higher rates of preventable diseases.

Access to care has been a particular problem for Medicaid. Some of the reasons Medicaid recipients may lack access to care are: a lack of providers willing to accept Medicaid reimbursements, recipient unfamiliarity with the health care system, inability of recipients to identify a "regular source of care," and cultural barriers.

Improving Access Via HMOs

In 1984, the state of Wisconsin initiated HMO care for AFDC/Healthy Start Medicaid recipients, in part to improve access to care for Medicaid recipients. Improved access may be anticipated in HMOs because HMOs provide a " medical home" for individuals and families, many of whom had no regular source of care. In addition, the state employs many contractual requirements aimed at improving access, appropriate utilization of health care services, and rates of preventive care. Examples of contractual requirements include transportation benefits, assuring an adequate provider network, and employing a culturally sensitive HMO advocate.

Measuring Access to Care

Measuring access to care is a challenge. In part, it depends upon patient perceptions of access, such as availability and timeliness of care. The number of office visits, emergency room visits, and rates of hospitalization have often been used to measure "access to care."

Children's Access to Acute and Preventive Care

Access to both acute care and preventive care is an important foundation for quality. Children's preventive care visits—called HealthChecks in Wisconsin—are an opportunity for assessing developmental milestones, administering immunizations, performing screening tests, and educating parents and patients (see glossary and Children's Preventive Health Care section for further discussion of HealthCheck exams).

For comprehensive care, both HealthCheck and non-HealthCheck visits are important. A non-HealthCheck visit is any visit to a practitioner for acute care, follow-up care, or as a result of a referral to a specialist.

Data in this report indicate that most HMOs (six of nine) had higher rates of combined HealthCheck and non-HealthCheck visits than fee-for-service (see Graph 4.1).[1] Five of nine HMOs also had higher rates of non-HealthCheck visits than fee-for-service (see Graph 4.2).

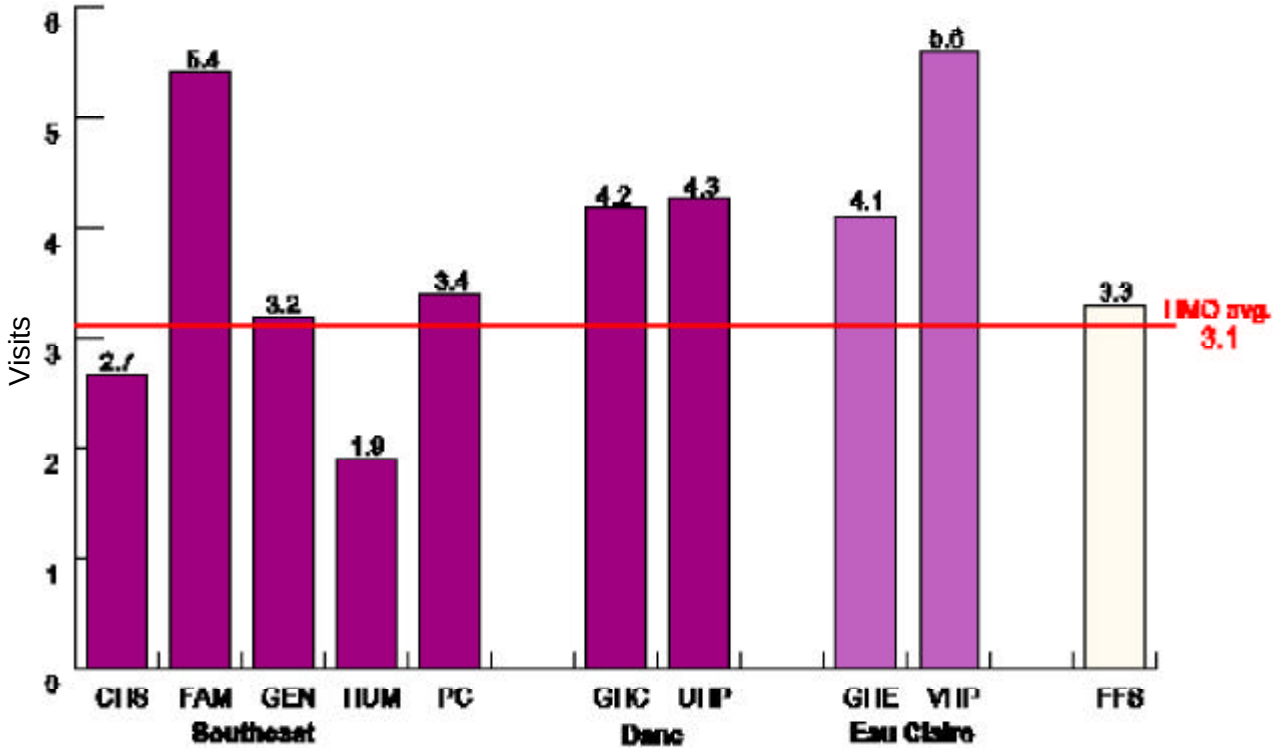
Importance of Primary Care Providers

Most Wisconsin HMOs require Medicaid members to choose a "primary care provider" (PCP). A primary care provider is that person's "regular doctor" and generally provides important preventive care, patient education, and treatment for common illnesses. Examples of primary care providers are physicians in general practice, family practitioners, internists, pediatricians and obstetrician-gynecologists, nurse midwives, physician assistants, and nurse practitioners.

AFDC/HS Medicaid recipients in Wisconsin enrolled in an HMO had statistically higher visitation rates to primary care providers compared to fee-for-service recipients (see Graph 4.3).[3]

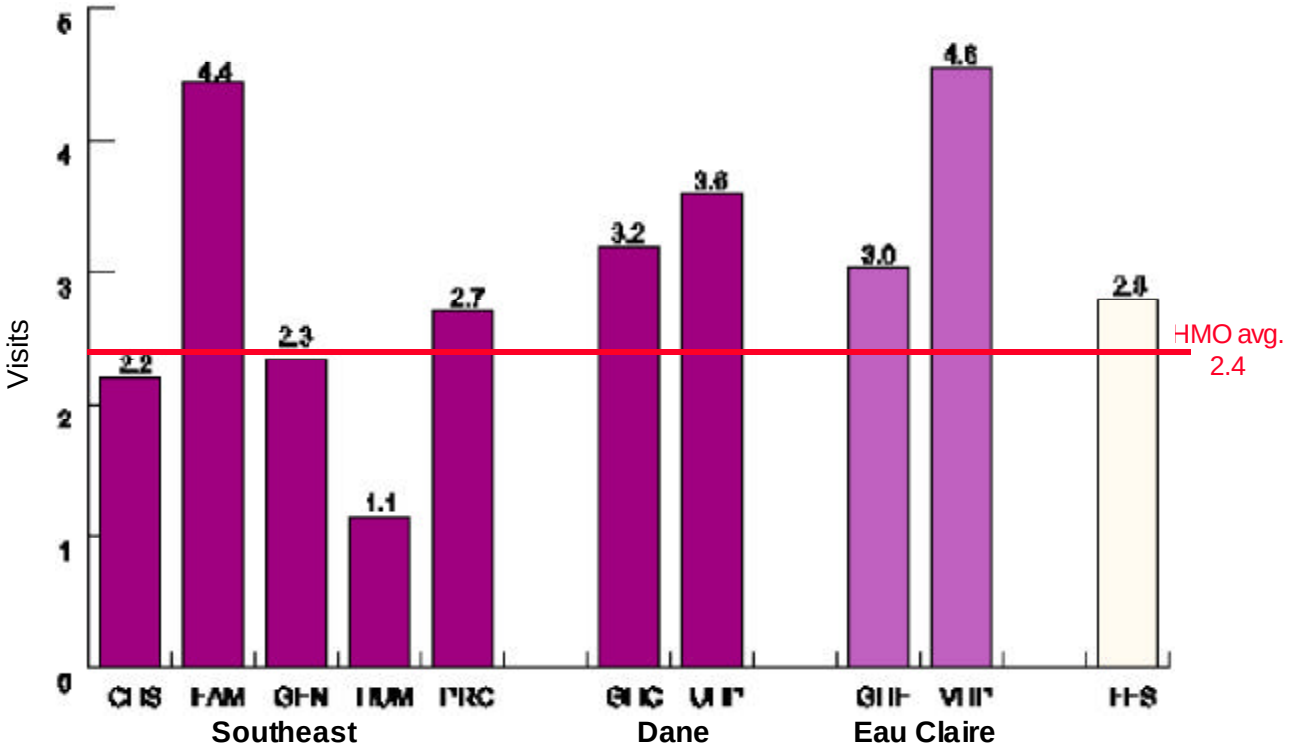
Graph 4.1[1,2]

Rate of combined HealthCheck and non-HealthCheck visits per eligible-year, ages 0-20, by HMO and fee-for-service, 1996



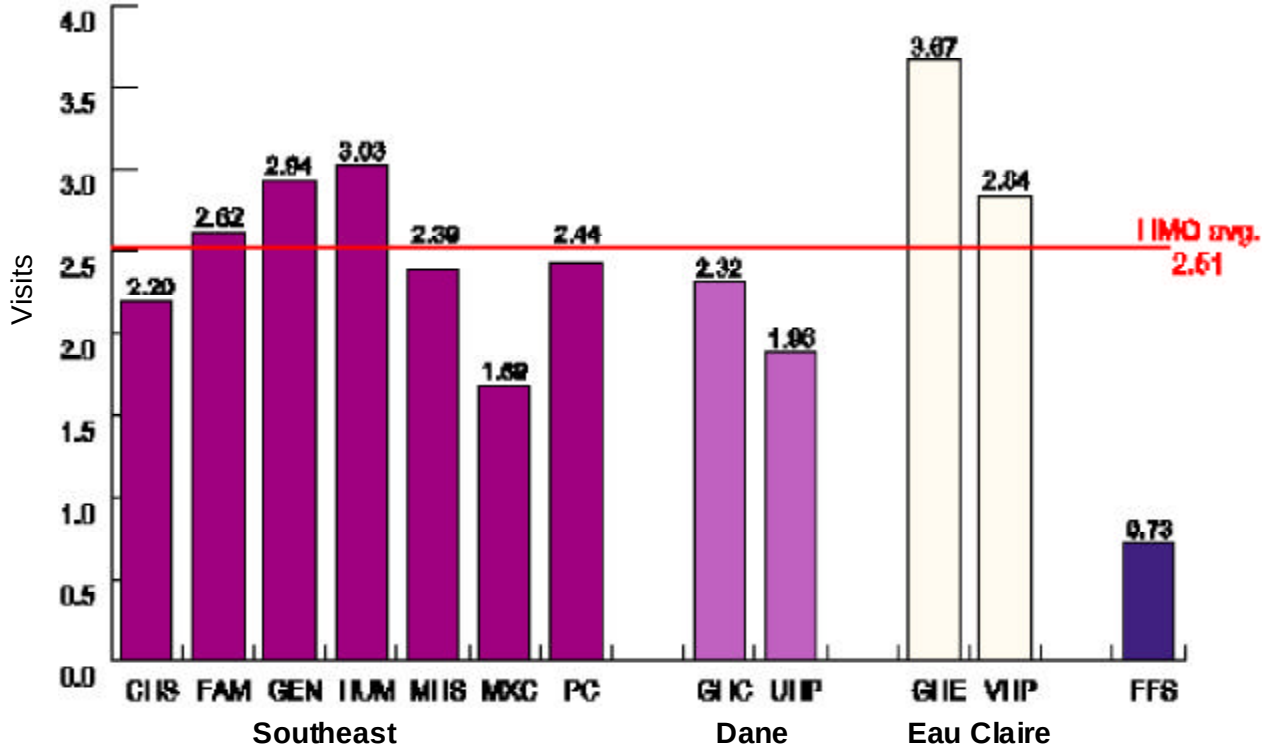
Graph 4.2[2]

Rate of non-HealthCheck visits per eligible-year, ages 0-20, by HMO and fee-for-service, 1996



Graph 4.3

Rate of primary care provider visits per eligible-year, for all ages, among HMOs and fee-for-service recipients, 1996

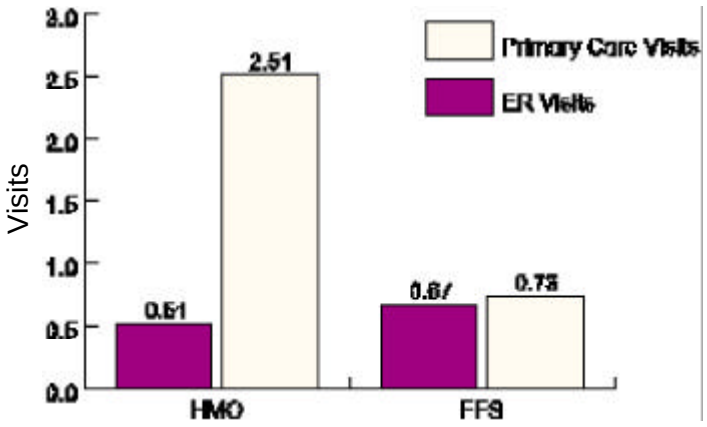


Overall, Medicaid HMO recipients had much higher rates of visits to primary care providers, while having lower emergency room utilization rates (see Graph 4.4). It has been reported elsewhere that Medicaid recipients who have access to primary care providers use emergency rooms less often.[4]

Lack of a primary care provider has been strongly associated with ER utilizations for minor problems.[6]

Graph 4.4

Average Medicaid HMO primary care visit rate and emergency room visit rate compared to fee-for-service primary care visit rate and emergency room visit rate, 1996



Emergency Room Visits in Wisconsin

Wisconsin residents visited an emergency room an estimated 723,000 times in 1995, according to the *1995 Wisconsin Family Health Survey*.[5] Emergency room utilization rates were higher for children, males, African-Americans, the poor, those less educated and those who were unemployed or children living with unemployed adults. A large number of ER visits

may occur for "nonurgent" reasons.[6]

Emergency Room Visits by Wisconsin AFDC/Healthy Start Medicaid Recipients

Since the beginning of Medicaid managed care in Wisconsin, emergency room utilization rates per eligible-year for AFDC/Healthy Start Medicaid recipients of all ages have been lower in HMOs than fee-for-service.

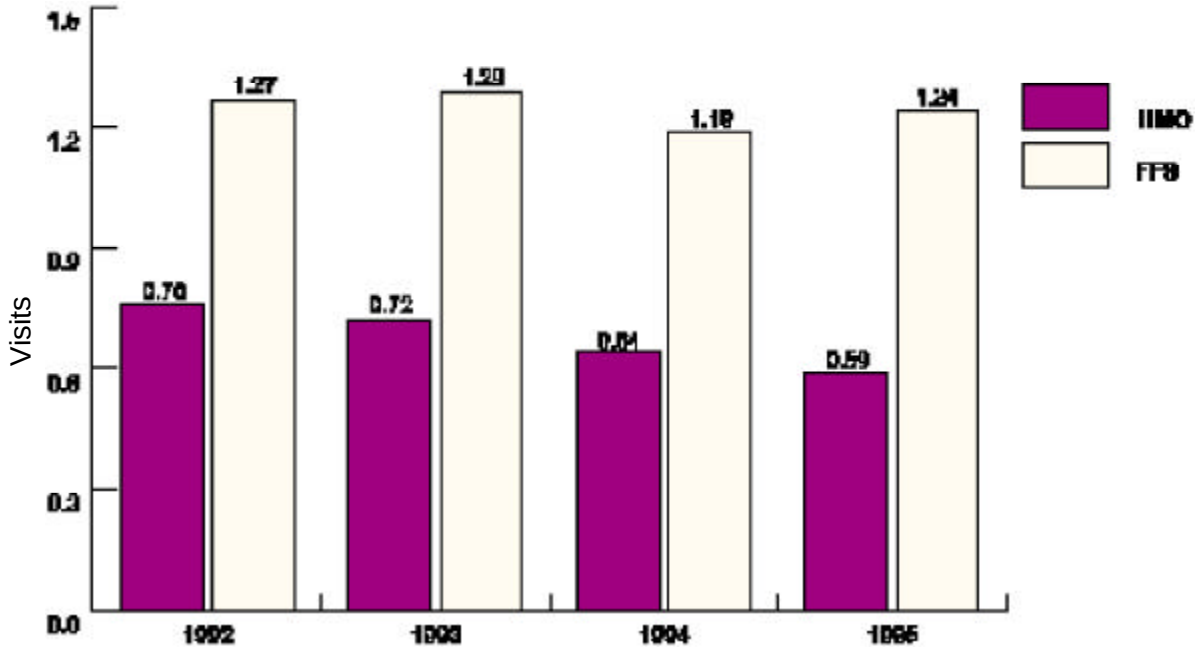
Graph 4.5 shows that for the years 1992-1995, Wisconsin Medicaid emergency room use by AFDC/Healthy Start Medicaid recipients of all ages was lower in HMOs than fee-for-service. Further, there has been a consistent downward trend across time for HMOs (a 22 percent drop), but not for fee-for-service.[7]

It should be noted that because 1996 ER utilization data included only "those ER visits that did not result in an admission," ER visit rates in this report are not completely comparable to previous years. This change was made in 1996 to focus on those ER visits that were most likely taking the place of visits to a primary care provider. Also, the 1996 data is consistent with national guidelines for HMO reporting (Health Plan Employer Data and Information Set).

In 1996, all but one HMO reported ER utilization rates that were much lower than fee-for-service (see Graph 4.6). ER utilization rates varied considerably among age groups (see Graph 4.7).

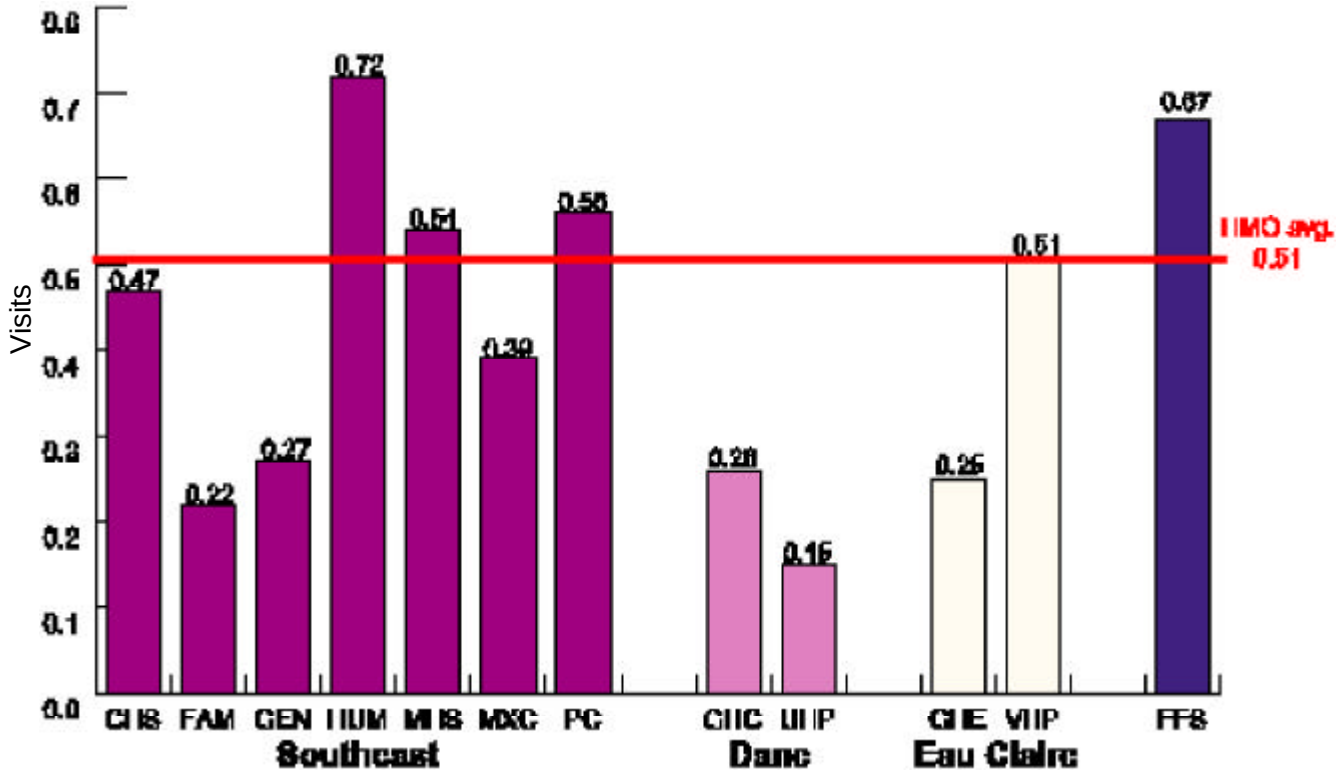
Self-reported data from combined *Family Health Survey* results for the years 1990-1994 showed young children ages 1-4 as having higher ER utilization rates (24 percent) compared to those ages 5-14 statewide (15 percent), and even higher rates among 1- to 4-year-olds on Medicaid (37 percent) (see Graph 4.8).[8] The survey findings appear to be quite consistent with Wisconsin Medicaid HMO and fee-for-service emergency room utilization patterns among children in

Graph 4.5
Emergency room visits per eligible-year, Medicaid HMO recipients and Medicaid fee-for-service recipients, 1992-1995



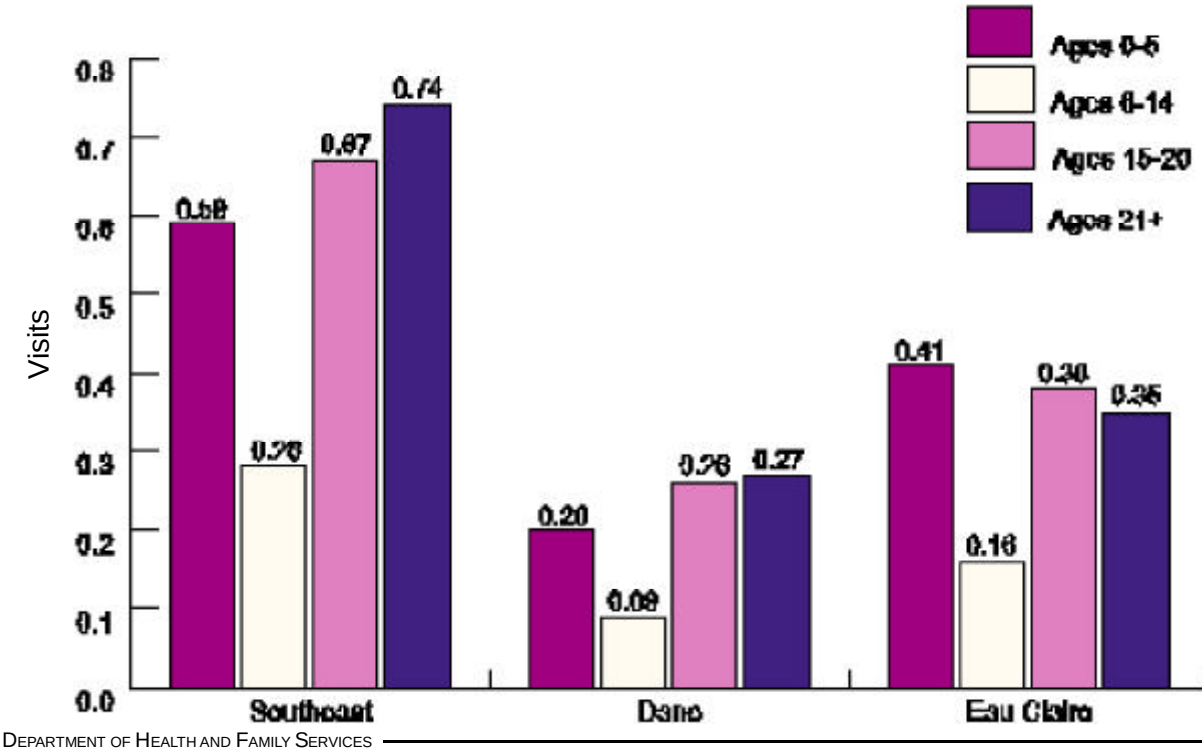
Graph 4.6

Rate of emergency room visits per eligible-year that did not result in an admission, by HMO and fee-for-service, all ages, 1996



Graph 4.7

Rate of emergency room visits that did not result in an admission, by HMO location and by age group, 1996



1996.

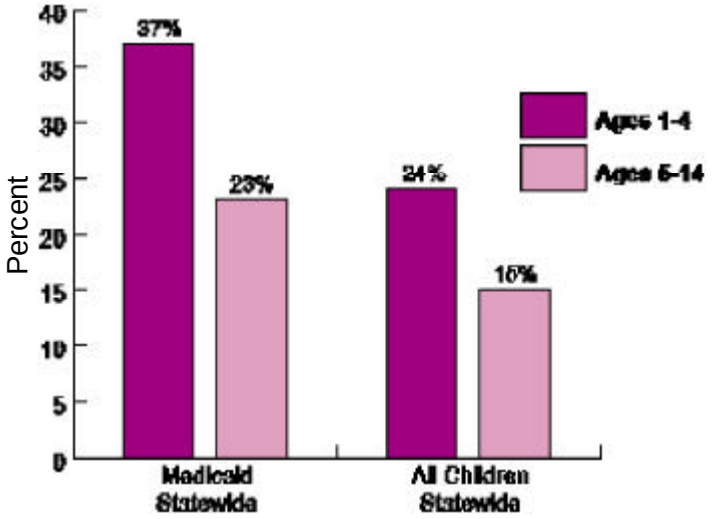
Relationship of Emergency Room Visit Rates to Other Ambulatory Visits

The percentage of ER visits as a proportion of all ambulatory care visits was much lower in HMOs than in fee-for-service with the exception of one HMO serving Southeast Wisconsin (see Graph 4.9). A lower percentage may reflect better access to primary care.

Endnotes

1 Abbreviations for HMOs in graphs are as follows:

Graph 4.8
Percent of children on Medicaid and all children statewide reporting treatment in an emergency room annually, 1990-1994



Graph 4.9[2]
Emergency room visits that did not result in an admission, as a percentage of all ambulatory care visits, by HMO and fee-for-service, ages 0-20, 1996